SUICIDE DEBATE: Part I – Flawed Theories

Said Shahtahmasebi, PhD.
The Goodlife Research Centre Trust
Correspondence: radisolevoo@gmail.com
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Abstract

In their critical review of Interpersonal Theory of Suicide (IPTS) Hjelmeland and Knizek (2019) question the popularity of IPTS without justification. There are several reasons why "experts" disseminate flawed theories. The latter, i.e. why a theory is flawed, is due to allowing bias and failing to account for it, for whatever reason including poor study design, and inappropriate analytical methodology. The former, i.e. why "experts" disseminate flawed theories has its roots in human behaviour including uncritical thinking, a lack of public discussion, researchers' status and power, and a desire not to rock the boat. In this paper, a pragmatic look at IPTS using substantive theory raises concern that such behaviour has brought academia and research in general into disrepute.

Theory or personal opinion

In a recent critical review of Interpersonal Theory of Suicide (IPTS) Hjelmeland and Knizek (Hjelmeland & Knizek, 2019) question the uncritical popularity of IPTS and systematically discredit this theory. They suggest that, given that the highest proportion of articles referring to IPTS were published in "Suicide and Life-Threatening behaviour" where the originator of IPTS is the editor-in-chief, may explain its rise in popularity.

The theory states that:-

> "Suicide can be explained by the simultaneous presence of three risk factors only, namely acquired capability for suicide, thwarted belongingness, and perceived burdensomeness."

Let's pause for a moment and analyse and digest this claim before seeking out background information. Hjelmeland and Knizek raise the point that there seems to be a general agreement amongst suicide researchers that suicide is a complex phenomenon so how can such a simplistic view be so easily and uncritically embraced?

Over and above the issue of the complexity of suicide (which I will come back to later) my first reactions to IPTS were (i) IPTS describes the feelings and views of a lot of migrants, refugees, people of ethnic minorities, incarcerated people, and people whose views and beliefs may not be aligned with perceived that of the mainstream, those living in low socio-economic areas, perceived social and economic isolation and abandonment, etc. the general population can easily be categorised into many groups with differing views, perception and expectations. And (ii) how does IPTS differ from the medical model that firmly believes that depression causes suicide?

On their webpage the APA (American Psychological Association https://www.apa.org/topics/depression/index.aspx) describes depression as:-

> "**Depression** is more than just sadness. People with depression may experience a lack of interest and pleasure in daily activities, significant weight loss or gain, insomnia or excessive sleeping, lack of energy, inability to concentrate, feelings of worthlessness or excessive guilt and recurrent thoughts of death or suicide."

And offer a treatment plan:-

> "Depression is the most common mental disorder. Fortunately, depression is treatable. A combination of therapy and antidepressant medication can help ensure recovery."

This definition of depression quite clearly describes IPTS and vice versa. It appears that the author of IPTS is claiming that for an individual to suicide s/he must be feeling a lack of interest in oneself or worthlessness (thwarted belongingness), guilt (burdensomeness), and recurrent thoughts of suicide (acquired capability to suicide), i.e. must be depressed. This new theory is an attempt to put a new gloss over the medical model of suicide without using the word "depression". The latter presents itself as the most likely motive given the mounting evidence against the medical model (e.g. see (CDC, 2018; Hjelmeland, Dieserud, Dyregrov, Knizek, & Leenaars, 2012; Shahtahmasebi, 2014a; WHO, 2014)).

However, Hjelmeland and Knizek question the incomprehensible popularity of IPTS and its uncritical application. Indeed, anyone with a little research experience and understanding of human behaviour would question its validity and applicability to suicide prevention. For example, for the purpose of understanding suicide better so that we can prevent it, what does "acquired capability for suicide" mean? How is it defined and quantified? How will it help prevent suicide? Are we to develop mental health clinics at every corner of our communities, schools and workplaces in order to subject the public to a check list of questions about whether or not they have thought about death?

It seems to me that IPTS supporters have reinvented the wheel and come up with a rectangle!

Such a theory will lead to the same suicide prevention scheme as the medical modellists have been dishing out for decades: "more of the same" mental health interventions! And as suicide statistics demonstrate the medical model of suicide intervention has failed to prevent suicide and break the cycles in the rising national and global suicide rates (Shahtahmasebi, 2018a, 2018b).

Another important and practical issue that seems to have been completely overlooked is that the three "risk" factors are subjective in nature. Subjective variables are the source of bias leading to spurious results and erroneous conclusions (Shahtahmasebi & Berridge, 2009). Thus IPTS's development process has been heavily biased from initial idea to study design, researchers and subjects, measurement tools and data collection, interpretation (Hjelmeland & Knizek, 2019; Shahtahmasebi, 2014a). This demonstrates a lack of insight not only into the topic but also into research methodology.

Indeed, Hjelmeland and Knizek's (Hjelmeland & Knizek, 2019) review of IPTS suggests a lack of understanding of such statistical concepts and is completely devoid of substantive theory. The critical review of IPTS (Hjelmeland & Knizek, 2019) demonstrates that this theory is nothing more than a personal opinion and a red herring in suicide prevention.

Although further analysis of IPTS is not necessary, the IPTS's background, and the supposed substantive theory that was used to develop IPTS, also deserves some attention.

Background to IPTS

Hjelmeland and Knizek (2019) suggest that the development of IPTS by Joiner was triggered by the suicide of Joiner's father as explained by him in a paragraph in his book:-

> "Of course my dad's death has deeply affected both my feelings about suicide and my understanding of it (…) My intellectual understanding of suicide evolved along a different track than my feelings. Informed by science and clinical work, I came to know more than most about suicide – on levels ranging from the molecular to the cultural. But here, too, my dad's death never left me, for the simple fact that I could evaluate theories and studies on suicide not only by formal professional and scientific criteria, but also by whether they fit with what I know about my dad's suicide. ((Joiner, 2005), p. 1)."

In this paragraph Joiner appears to confess to being emotive about suicide, whilst on the one hand he attempted to stay on the side of science, on the other hand Joiner admits that he evaluated theories and studies of suicide by how well they fitted with his knowledge of his father's suicide. It is one thing to compare and contrast one suicide with another, but to actually use personal opinion of suicide to evaluate studies is completely wrong.
To claim to know anything about suicide let alone more than most is quite bewildering and bemusing.

The implication of such a statement is that Joiner's knowledge of suicide is the "truth".

The alternative truth is, if suicide was understood then national and global suicide rates would be trending down not up (Pridmore & Shahtahmasebi, 2018). In other words, Joiner's understanding of suicide had evolved through his feelings about his father's suicide which he used to develop IPTS.

But feelings, views, attitudes, and perceptions change over time. To evaluate research according to a personal opinion carries the danger of rejecting a research without justification, or forcing it to fit into a preconceived idea.

At face value, in this paragraph Joiner is describing himself as a suicide survivor (family and friends who have lost a loved one to suicide). However, this paragraph is self-serving and is devoid of empathy and sympathy. It resonates the words of another medical modellist who claimed that only the people who are psychiatrically trained can comment on suicide (in (Hjelmeland & Knisek, 2017), page 5&6). By placing the emphasis on himself Joiner is excluding other suicide survivors.

It only takes some empathy and time to sit with and listen to suicide survivors without prejudice (Shahtahmasebi, 2014b, 2016). Then, it is not too difficult to see that Joiner's feelings and claims about understanding suicide are no different to that of many thousands of other suicide survivors. They, too, after months and years of soul searching, believe they understand suicide. Some go on to set up self-help groups, advocacy groups, and campaign for suicide prevention.

Unfortunately, experience suggests that such groups tend to become dangerously fixated on their own personal opinions of suicide and suicide prevention formed in the absence of quality information and public discussion of suicide.

Thus, IPTS is yet another survivor's reaction to the suicide of a loved one - its developmental process is based on a lack of quality and relevant and appropriate information and public discussion of suicide. IPTS is very subjective and is nothing more than a personal opinion. This makes it difficult to believe that IPTS can predict future suicides.

Concluding comments

Personal beliefs such as IPTS do not add any insight nor do they contribute to the suicide debate. We are none the wiser; not only do we still not understand suicide, but also there has been no sustainable reduction in suicide rates; medium to long term suicide trends are generally upward.

It is total nonsense that any model can explain and then predict future suicide - the rising suicide rates across the globe provide strong evidence that we simply do not understand suicide.

A main feature of suicide rates is its cyclic pattern. Researchers and policy makers have over the past decades abused this feature: when the cycle has peaked and is on the downturn it is claimed that suicide prevention policies are working and more funding is demanded to apply more of the same policies. And when the cycle is bottomed out and going up it is claimed that suicide is a very complex social and mental health problem and more funding is needed for further research.

Complex multifactorial suicide can, at least in part, be explained by the clustering pattern in suicide rates. The cyclic pattern means that each suicide category e.g. age groups (adolescents/25-34/ etc), gender (male/female), occupations (farmers/pilots/doctors/ etc), mental disorder etc also follow a cyclic pattern but each have a different start and end cycle. There is a lagging effect between all groups – so while suicide may be trending down for some groups it will be trending up for others – or appears stationary for some other groups. In other words, suicide is examined from every perspective and the numbers are analysed according to age, gender, religion, socioeconomic and employment status, and geographical location, to name but a few. It is not surprising that if you look at data repeatedly, you will eventually come up with something which looks "significant".

A major feedback effect of such behaviour has been two-fold, specifically, not only have we not progressed our understanding of suicide beyond its dictionary definition, we have made it such a complex problem so that we are unable to resolve it. In other words, researchers, politicians, the public and other stakeholders have become part of the suicide problem.

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